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Staphylococcus aureus Resistant to Vancomycin — United States, 2002

Staphylococcus aureus is a cause of hospital- and community-acquired infections (*1,2*). In 1996, the first clinical isolate of *S. aureus* with reduced susceptibility to vancomycin was reported from Japan (*3*). The vancomycin minimum inhibitory concentration (MIC) result reported for this isolate was in the intermediate range (vancomycin MIC=8 μg/mL) using interpretive criteria defined by the National Committee for Clinical Laboratory Standards (*4*). As of June 2002, eight patients with clinical infections caused by vancomycin-intermediate *S. aureus* (VISA) have been confirmed in the United States (*5,6*). This report describes the first documented case of infection caused by vancomycin-resistant *S. aureus* (VRSA) (vancomycin MIC $\geq$32 μg/mL) in a patient in the United States. The emergence of VRSA underscores the need for programs to prevent the spread of antimicrobial-resistant microorganisms and control the use of antimicrobial drugs in health-care settings.

In June 2002, VRSA was isolated from a swab obtained from a catheter exit site from a Michigan resident aged 40 years with diabetes, peripheral vascular disease, and chronic renal failure. The patient received dialysis at an outpatient facility (dialysis center A). Since April 2001, the patient had been treated for chronic foot ulcerations with multiple courses of antimicrobial therapy, some of which included vancomycin. In April 2002, the patient underwent amputation of a gangrenous toe and subsequently developed methicillin-resistant *S. aureus* bacteremia caused by an infected arteriovenous hemodialysis graft. The infection was treated with vancomycin, rifampin, and removal of the infected graft. In June, the patient developed a suspected catheter exit-site infection, and the temporary dialysis catheter was removed; cultures of the exit site and catheter tip subsequently grew *S. aureus* resistant to oxacillin (MIC >16 μg/mL) and vancomycin (MIC >128 μg/mL). A week after catheter removal, the exit site appeared healed; however, the patient's chronic foot ulcer appeared infected. VRSA, vancomycin-resistant *Enterococcus faecalis* (VRE), and *Klebsiella oxytoca* also were recovered from a culture of the ulcer. Swab cultures of the patient's healed catheter exit site and anterior nares did not grow VRSA. To date, the patient is clinically stable, and the infection is responding to outpatient treatment consisting of aggressive wound care and systemic antimicrobial therapy with trimethroprim/sulfamethoxazole.

The VRSA isolate recovered from the catheter exit site was identified initially at a local hospital laboratory using commercial MIC testing and was confirmed by the Michigan Department of Community Health and CDC. Identification methods used at CDC included traditional biochemical tests and DNA sequence analysis of *gyrA* and the gene encoding 16S ribosomal RNA. Molecular tests for genes unique to enterococci were negative. The MIC results for vancomycin, teicoplaninin, and oxacillin were >128 μg/mL, 32 μg/mL, and >16 μg/mL, respectively, by the broth microdilution method. The isolate contained the *vanA* vancomycin resistance gene from enterococci, which is consistent with the glycopeptide MIC profiles. It also contained the oxacillin-resistance gene *mecA*. The isolate was susceptible to chloramphenicol

INSIDE

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linezolid, minocycline, quinupristin/dalfopristin, tetracycline, and trimethoprim/sulfamethoxazole.

Epidemiologic and laboratory investigations are under way to assess the risk for transmission of VRSA to other patients, health-care workers, and close family and other contacts. To date, no VRSA transmission has been identified.

Infection-control practices in dialysis center A were assessed; all health-care workers followed standard precautions consistent with CDC guidelines (*7*). After the identification of VRSA, dialysis center A initiated special precautions on the basis of CDC recommendations (*8*), including using gloves, gowns, and masks for all contacts with the patient; performing dialysis with a dedicated dialysis machine during the last shift of the day in an area separate from other patients; having a dialysis technician dedicated to providing care for the patient; using dedicated, noncritical patient-care items; and enhancing education of staff members about appropriate infection-control practices. Assessment of infection-control practices in other health-care settings in which the patient was treated is ongoing.

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Editorial Note: This report describes the first clinical isolate of *S. aureus* that is fully resistant to vancomycin. *S. aureus* causes a wide range of human infections and is an important cause of health-care associated infections. The introduction of new classes of antimicrobials usually has been followed by emergence of resistance in *S. aureus*. After the initial success of penicillin in treating *S. aureus* infection, penicillin-resistant *S. aureus* became a major threat in hospitals and nurseries in the 1950s, requiring the use of methicillin and related drugs for treatment of *S. aureus* infections. In the 1980s, methicillin-resistant *S. aureus* emerged and became endemic in many hospitals, leading to increasing use of vancomycin. In the late 1990s, cases of VISA were reported.

Although the acquired vancomycin-resistance determinants *vanA*, *vanB*, *vanD*, *vanE*, *vanF*, and *vanG* have been reported from VRE, these resistance determinants have not previously been identified in clinical isolates of *S. aureus* (*9*). Conjugative transfer of the *vanA* gene from enterococci to *S. aureus* has been demonstrated *in vitro* (*10*). The presence of *vanA* in this VRSA suggests that the resistance determinant might have been acquired through exchange of genetic material from the vancomycin-resistant enterococcus also

isolated from the swab culture. This VRSA isolate is susceptible *in vitro* to several antimicrobial agents, including antimicrobials recently approved by the Food and Drug Administration (i.e., linezolid and quinupristin/dalfopristin) with activity against glycopeptide-resistant Gram-positive microorganisms.

In 1997, the Healthcare Infection Control Practices Advisory Committee published guidelines for the prevention and control of staphylococcal infection associated with reduced susceptibility to vancomycin (*8*); plans to contain VISA/VRSA on the basis of CDC recommendations have been established in some state health departments. In the health-care setting, a patient with VISA/VRSA should be placed in a private room and have dedicated patient-care items. Health-care workers providing care to such patients should follow contact precautions (i.e., wearing gowns, masks, and gloves and using antibacterial soap for hand washing). These control measures were adopted by dialysis center A immediately following confirmation of the VRSA isolate. To date, there has been no documented spread of this microorganism to other patients or health-care workers.

Strategies to improve adherence to current guidelines to prevent transmission of antimicrobial resistant microorganisms in health-care settings should be a priority for all health-care facilities in the United States. *S. aureus* should be tested for resistance to vancomycin using a MIC method. The isolation of *S. aureus* with confirmed or presumptive vancomycin resistance should be reported immediately through state and local health departments to the Division of Healthcare Quality Promotion, National Center for Infectious Diseases, CDC, telephone 800-893-0485.

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Heat-Related Deaths — Four States, July–August 2001, and United States, 1979–1999

Each year in the United States, approximately 400 deaths are attributed to excessive natural heat; these deaths are preventable (*1*). This report describes heat-related deaths in Missouri, New Mexico, Oklahoma, and Texas when elevated temperatures were recorded for several consecutive days during July–August 2001; summarizes heat-related deaths in the United States during 1979–1999; and presents risk factors and preventive measures associated with heat-related illness and death, especially in susceptible populations.

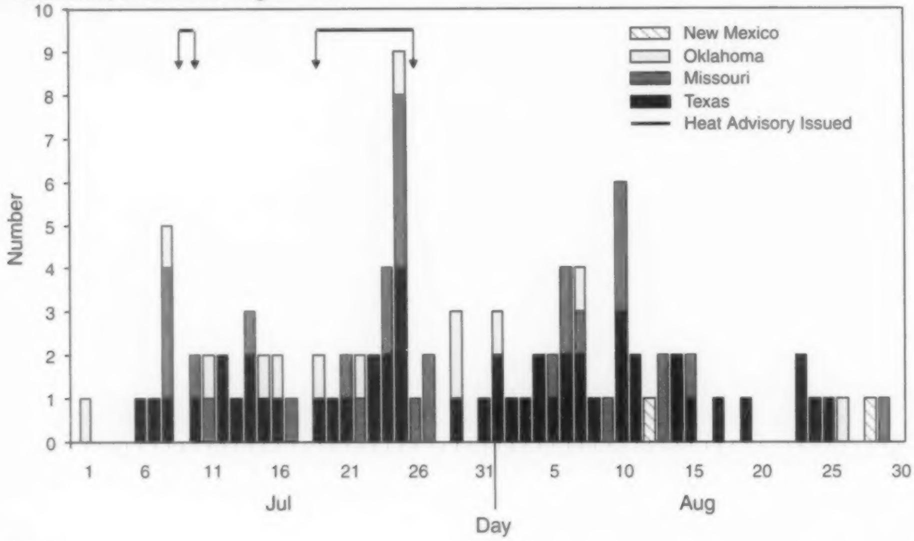
In late July 2001, the National Oceanographic and Atmospheric Association (NOAA) reported temperatures averaging 5° F (-15° C)–10° F (-12° C) above normal in the southern plains states (*2*). The intense heat and humidity prompted NOAA's National Weather Service to issue heat advisories* in Missouri, New Mexico, Oklahoma, and Texas (*2*; Missouri Department of Health and Senior Services, personal communication 2002). During July–August 2001, a total of 95 deaths was attributed to excessive natural heat in the affected states. Provisional mortality statistics were obtained from the vital statistics section of each state, and information about underlying cause of death, age, sex, date of death, and contributing causes were provided. Peak mortality occurred during the reported 8-day heat advisory period (Figure 1). Six (6%) deaths occurred among children aged $\leq$4 years and 42 (41%) among persons aged $\geq$75 years; 69 (73%) deaths occurred among males.

Case Reports

Case 1. In Oklahoma in mid-July 2001, a man aged 29 years was found disoriented and wandering in a commercial parking lot. He apparently had fallen and had abrasions on his knees and a broken tooth. In the emergency department,

*The National Weather Service issues a heat advisory when the maximum daytime heat index is expected to be $\geq$105° F (40.6° C) and the minimum nighttime heat index is expected to be 80° F (26.7° C) for 2 or more consecutive days. The heat index takes into account air temperature and relative humidity and indicates the actual feel of the temperature to the body.

FIGURE 1. Reported cases of heat-related deaths*, by date and site — Missouri, New Mexico, Oklahoma, and Texas, August 2001



* n=95.

incoherent on the street. A witness reported that he had complained about abdominal pain and vomiting. He arrived at an emergency department in New Mexico 3 hours after he was found. His rectal temperature was 105.7° F (40.9° C). The patient had laboratory evidence of rhabdomyolysis, severe dehydration, and renal failure. Blood alcohol level and a screen for drugs were negative. He died 3 hours after arrival at the hospital. Cause of death was attributed to hyperthermia due to environmental heat exposure. High temperature at the border that day was 90° F (32° C).

he was semiconscious but combative. His rectal temperature increased from 105.4° F (40.7° C) to 107.8° F (42.1° C) in <1 hour. Despite medical treatment for hyperthermia, he was pronounced dead 22 hours after being found. Laboratory tests at autopsy were positive for cocaine and alcohol. The medical examiner attributed the cause of death to heat-related illness.

Case 2. In Oklahoma in mid-July 2001, police were called to check on a man aged 62 years with a history of alcoholism, heavy smoking, and poor diet who had not been seen for 7 days. The man was found dead by the police in his home, which was very hot; an ambient temperature was not recorded. A fan and air-conditioning unit in the home were in working order but turned off. Postmortem blood alcohol level was 0.07%. Following an autopsy, the death was attributed to hyperthermia.

Case 3. In Texas in late July 2001, a boy aged 2 years was found in a motor vehicle with the windows rolled up for an undetermined length of time. The boy had locked himself in the car and could not get out. The temperature inside the car was not measured, nor was the outside temperature recorded; however, the high temperatures in central Texas during this time ranged from the mid-to-high 90s. The boy arrived at the hospital with an oral temperature of 102° F (39° C) and died 2 days later. The death was attributed to heatstroke.

Case 4. In a border town in Chihuahua State, Mexico, in August 2001, a man aged 21 years was found collapsed and

United States

During 1979–1999, a total of 8,015 deaths in the United States was associated with excessive heat exposure†, 3,829 (48%) were "due to weather conditions," 377 (5%) were "of man-made origins" (i.e., heat generated in vehicles, kitchens, boiler rooms, furnace rooms, and factories), and 3,809 (48%) were "of unspecified origin" (*3*); 182 deaths per year (range: 54–651) were associated with excessive heat due to weather conditions. Of the 3,764 (98%) deaths specified as due to weather conditions with a reported age (*3*), 142 (4%) occurred among children aged ≤4 years, and 1,068 (28%) occurred among persons aged ≥75 years (Figure 2).

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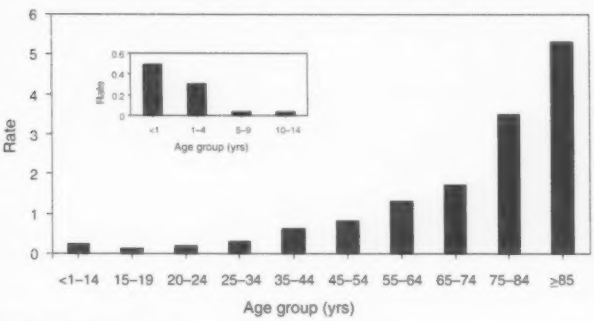
Editorial Note: The cases summarized in this report demonstrate risk factors for heat-related illness. Heat-related illnesses include sunburn, heat cramps, heat rash, heat exhaustion, and heatstroke. Of these, the two most serious types of heat-related illness are heat exhaustion and heatstroke, both of

†Underlying cause of death during 1979–1998 is classified according to the *International Classification of Disease, Ninth Revision* (ICD-9). Excessive heat has three categories: E900.0 "due to weather conditions," E900.1 "of man-made origins," and E900.9 "of unspecified origin." The data for 1999 are from ICD-10; code X30 "exposure to excessive natural heat" was added to the 1979–1998 ICD-9 code E900.0, "excessive heat due to weather conditions."

FIGURE 2. Average annual rate* of heat-related deaths attributed to weather conditions† and exposure to excessive natural heat§, by age group — United States, 1979–1999



* Per million population.
† *International Classification of Diseases, Ninth Revision* (ICD-9), code E900.0.
§ ICD-10, code X30.

which can result in death. Symptoms of heat exhaustion include heavy sweating, muscle cramps, fatigue, weakness, paleness, cold or clammy skin, dizziness, headache, nausea or vomiting, and fainting. Untreated heat exhaustion can progress to heatstroke (*4*). Even with prompt medical care, 15% of heatstroke cases are fatal (*5*).

Symptoms of heatstroke include a high body temperature (oral temperature of ≥103° F [≥39.4° C] or a rectal temperature of 106° F [41.1° C]); red, hot, dry skin and no sweating; rapid pulse; throbbing headache; dizziness; nausea; confusion; disorientation; delirium; and coma. Heatstroke can occur in the absence of physical exertion. Infants, elderly persons, socially isolated persons, bedridden persons, and persons with certain mental and chronic illnesses are at highest risk (*6,7*). The elderly, especially those aged ≥80 years, are susceptible to heat-related illness because they are less able to adjust to physiologic changes (e.g., vasodilation) that occur with exposure to excessive heat and are more likely to be taking medication for chronic illness (e.g., tranquilizers and anticholinergics) that increase the risk for heat-related illness (*5*). Infants also are sensitive to heat. Conditions such as mild fever can progress quickly to heatstroke if heat stress occurs. Parents and other caregivers should provide adequate hydration during summer months and refrain from dressing children too warmly (*5*). Adults also should keep well hydrated during summer months.

Heatstroke also can occur in young, healthy persons who are exercising (*6*), because physical exertion during hot weather increases the likelihood of fainting and cramps caused by increased blood flow to the extremities (*5*). Onset of heatstroke can be rapid and is considered a medical emergency.

The findings in this report are subject to at least three limitations. First, information on decedents is provided by surrogates, who might not accurately describe characteristics or behavior of the decedents. Second, heat-related deaths due to weather conditions or exposure to excessive natural heat might represent only a portion of actual heat-related deaths. These deaths often are a diagnosis of exclusion and can be misclassified as a stroke or heart attack. Deaths attributed to cardiovascular and respiratory disease increase following heat waves (*8*). In addition, jurisdictions might use different definitions of heat-related death. Finally, ICD-10 coding was introduced in 1999 and might not be comparable with previous data for 1979–1998.

To reduce morbidity and mortality from heat-related illness, many cities have developed emergency response plans. Local officials use meteorologic information and assess population characteristics to implement prevention strategies (*7*). Spending time in an air-conditioned area is the strongest factor in preventing heat-related deaths (*1,9*). The use of fans does not appear to be protective during periods of high heat and humidity (*1*). If exposure to heat cannot be avoided, prevention measures should include reducing or eliminating strenuous activities or rescheduling them for cooler parts of the day; drinking water or nonalcoholic fluids frequently; taking cool showers frequently; wearing lightweight, light-colored, loose-fitting clothing; and avoiding direct sunshine (*9*).

Public health messages disseminated to all age groups can make the public aware of the signs and symptoms of heat-related illness. Prevention messages delivered as early as possible in the media can prevent heat-related illness, injury, and death (*1*).

Because many heat-related illnesses and deaths occur among the elderly population, older persons should be encouraged to take advantage of air-conditioned environments (e.g., shopping malls, senior centers, and public libraries) for part of the day. Parents and other caregivers should be educated about the heat sensitivity of children aged <5 years (*5*).

Acknowledgments

Case reports are based on data contributed by F Jordan, MD, Oklahoma Office of the Chief Medical Examiner. PJ McFeeley, MD, M Markey, MD, New Mexico Office of the Medical Investigator and Univ of New Mexico School of Medicine. N Peerwani, MD, L Anderson, Office of Chief of Medical Examiner, Tarrant County, Texas.

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Injuries and Deaths Among Children Left Unattended in or Around Motor Vehicles — United States, July 2000–June 2001

National attention concerning motor vehicles (MVs) and child safety has focused largely on protecting children as occupants transported in traffic on public roads. However, children who are unattended in or around MVs that are not in traffic also are at increased risk for injury and death. CDC and the nonprofit Trauma Foundation examined data from two databases on both nonfatal and fatal nontraffic MV-related incidents. This report summarizes the results of that analysis, highlights the major causes of this type of childhood death and injury, and underscores the need for effective interventions.

Nationally representative data on nonfatal injuries treated in hospital emergency departments (EDs) from the National Electronic Injury Surveillance System All Injury Program (NEISS-AIP) were examined (*1*). Data on fatal injuries occurring across the country were reported from a database developed by the Trauma Foundation's KIDS 'N CARS™ program. During July 2000–June, 2001, data from these two programs documented an estimated 9,160 nonfatal injuries and 78 fatal injuries among children aged ≤14 years who were left unattended in or around MVs that were not in traffic.

NEISS-AIP, which is operated by the U.S. Consumer Product Safety Commission, collects data annually on approximately 500,000 cases from a nationally representative sample of 65 hospital EDs in the United States. National estimates of nonfatal injuries treated in hospital EDs were calculated by using the sum of sample weights of study cases; weights were derived based on the inverse of the probability of selection; confidence intervals (CIs) were computed by using a direct variance estimation procedure (*1*). Population estimates for computing rates were obtained from the U.S. Bureau of Census.

NEISS-AIP study case-patients were children treated in a U.S. hospital ED after being injured while left unattended in or around MVs (e.g., cars, trucks, vans, and SUVs) not in traffic. These nontraffic injuries included those associated with 1) parked MVs on or off the street and 2) MVs in motion off the street. Children injured during the normal course of getting in or out of stationary MVs were excluded.

NEISS-AIP obtains data routinely for each nonfatal injury on the principal diagnosis, body part primarily affected, ED discharge disposition, and locale of occurrence (e.g., home or public place). Narratives describing each injury event were used to identify the surface where the incident occurred (e.g., driveway, parking lot, or street) and type of event. A classification scheme assigned cases to the following types of events: run over or backed over by an MV, struck by an MV, fell out of an MV in motion, or fell off of the exterior of an MV (e.g., the bed of a pick-up truck), and other specified (e.g., bumped against, dragged by, submerged in, or overheated in an MV).

The KIDS 'N CARS™ database was used to describe specific incidents involving children aged ≤14 years who died as a result of being left unattended in or around MVs. National estimates of fatalities cannot be derived from this database. KIDS 'N CARS™ identifies cases through 1) online searches of LexisNexis™, a service providing access to thousands of newspapers and magazines worldwide; 2) keyword searches on Internet search engines, the registration of keyword preferences with Internet providers and news media sites, and searches within archives of newspaper websites; 3) news accounts from a clipping service; 4) contacts with child death review teams; and 5) information from an informal nationwide network of professional and personal contacts. Documentation from news media archives and other record sources is used to validate all cases identified.

A total of 192 NEISS-AIP study cases was identified, representing a national estimate of 9,160 (95% CI=5,344–12,976) children with nonfatal injuries treated in U.S. hospital EDs during July 2000–June 2001. Approximately 42% of injured children were aged ≤4 years, and 61.9% were male (Table 1). Injuries occurred predominantly to the head and neck region (30.4%) and the extremities (53.1%). Most (56.8%) injuries were minor contusions and abrasions; however, more serious injuries also were common (26.5% were

TABLE 1. Estimated number and rate* of injuries treated in hospital emergency departments among children aged ≤14 years who were left unattended in or around motor vehicles — United States, July 2000–June 2001

Characteristic	No.	%	Rate	(95% CI†)
Age (yrs)				
0– 4	3,800	41.5	20.1	(8.5–31.7)
5–14	5,360	58.5	13.5	(8.4–18.5)
Sex				
Male	5,674	61.9	18.9	(11.0–26.8)
Female	3,486	38.1	12.2	(6.1–18.2)
Total	**9,160**	**100.0**	**15.6**	**(9.1–22.1)**

* Per 100,000 population.
† Confidence interval.

fractures or internal injuries). Most (81.8%) injured children were treated and released from the ED. Most injuries occurred near the home (47.8%) or on public property (31.1%). Injuries occurred in driveways and parking lots in at least 27.2% of incidents (Table 2). The most common type of nonfatal incident was being struck by an MV, followed by being run over or backed over by an MV and falling out or off of an MV. For nonfatal incidents, approximately 70% of MVs were moving at a slow speed (e.g., moving forward or backward shortly after being set in motion), and approximately 20% were moving backward.

The KIDS 'N CARS™ database provided information on 78 children who died during July 2000–June 2001 in 76 separate incidents. Fatalities occurred in 28 states and the District of Columbia. Of the fatally injured children, 64 (82.1%) were aged <4 years, and 42 (53.8%) were male. In 57 (73.1%) cases, the MV was located near a home (e.g., driveway, unpaved area near home, or street in front of home); in 39 (50%) cases, the child lived at that home. The driver was the parent in 12 (57.1%) of the 21 cases in which a child was backed over. The most common type of fatal incident was exposure to excessive heat inside an MV (e.g., when a child was left inside an MV during hot weather) (34.6%), followed by being backed over and being hurt when a child put an MV in motion (26.9%). Approximately 82% of fatal injuries occurred among children aged <4 years (Figure).

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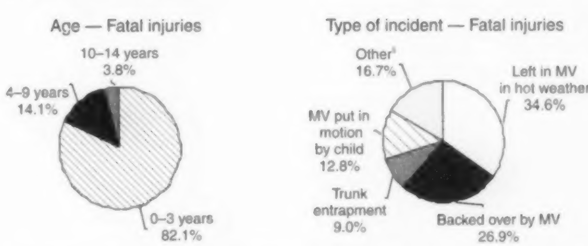
Editorial Note: The findings in this report highlight the characteristics of nontraffic-related injuries and deaths among children. Many more U.S. children aged ≤14 years are injured (e.g., an estimated 37,115 [CI=21,029–53,200] injury-related ED visits in 2000) or killed (e.g., 533 deaths in 1999) by being struck by a moving MV while in the street.

TABLE 2. Estimated number and percentage of injuries treated in hospital emergency departments among children aged ≤14 years who were left unattended in or around motor vehicles (MVs), by selected characteristics — United States, July 2000–June 2001

Characteristic	No.	%	(95% CI*)
Body part primarily affected			
Head/neck	2,783	30.4	(12.3– 48.5)
Extremity	4,860	53.1	(30.5– 75.6)
Other/unspecified	1,517†	16.6†	(6.3– 26.8)
Diagnosis			
Contusion/abrasion	5,205	56.8	(29.6– 84.0)
Fracture	1,212	13.2	(6.2– 20.3)
Internal injury/concussion	1,217†	13.3†	(3.8– 22.7)
Other	1,526	16.7	(9.7– 23.6)
Disposition at ED discharge			
Treated and released	7,496	81.8	(48.7–114.9)
Hospitalized/transferred	1,664†	18.2†	(6.8– 29.6)
Place of occurrence			
Home	4,378	47.8	(25.7– 69.9)
Public area§	2,852	31.1	(13.0– 49.3)
Unspecified	1,930	21.1	(11.7– 30.4)
Surface of occurrence			
Driveway/parking lot	2,495	27.2	(10.9– 43.5)
Other/unspecified¶	6,665	72.8	(43.2–102.3)
Type of MV-related event			
Run over/backed over by MV	2,767	30.2	(12.7– 47.7)
Struck by MV	3,414	37.3	(23.4– 51.1)
Fell out/fell off of MV	1,705	18.6	(8.1– 29.1)
Other**	1,274	13.9	(6.3– 21.5)
Total	**9,160**	**100.0**	

* Confidence interval.
† Estimate might be unstable because the coefficient of variation was >30%.
§ Includes school, store, restaurant, park, recreation area, sports arena, and other public place.
¶ Includes street.
** Includes pinned between MV and object, dragged by MV, submerged in water in MV, overheated in MV, and ran into MV.

FIGURE. Distribution* of fatal injuries among children aged ≤14 years injured in or around motor vehicles (MVs)†, by age and type of incident for cases reported — United States, July 2000–June 2001



* Percentile distributions are based on 78 KIDS 'N CARS™ cases of fatal injuries; these distributions are not nationally representative.
† n=78.
§ Other includes death in or around MV by fire, power accessories, entanglement in restraint straps, carbon monoxide poisoning, and left in MV in cold weather.

However, the nontraffic-related incidents described in this report are an important cause of injuries and deaths among children. These incidents are preventable, and effective interventions must be determined to protect children.

The findings in this report are subject to at least six limitations. First, NEISS-AIP captures only injuries treated in hospital EDs and does not include children seen in physicians' offices and clinics. Second, NEISS-AIP provides statistically valid national estimates but not state and local estimates. Third, types of nonfatal incidents were classified by using brief narratives transcribed from medical records; further details about each incident were not available. Fourth, KIDS 'N CARS™ data are not population-based and probably undercount the true number of fatal cases nationally. Fifth, media coverage of these incidents might contain incomplete information and might be less common in large urban areas. Finally, online media archives might exclude very small-circulation local newspapers. Because of these limitations, methods should be explored to obtain routine national data useful for characterizing and monitoring detailed circumstances of injuries and deaths from all types of nontraffic MV-related incidents involving children. The National Highway Traffic Safety Administration is assessing methods to identify cases of nontraffic MV-related injuries and deaths in children and to obtain details about injury-related circumstances (*2*).

The findings in this report are consistent with other studies that indicate that children left unattended in or around MVs are at increased risk for injury and death in incidents that involve parked MVs, slow-moving MVs, MVs moving backward in driveways and parking lots, MVs set in motion by a child, and trunk entrapment (*3–10*). In this report, excessive heat exposure while in an MV was the most common cause of death; however, scientific literature examining the circumstances of such incidents is minimal.

Several areas for possible intervention include education, legislation, regulation, and changes in vehicle design. Education campaigns aimed at parents and caregivers should communicate the following: 1) ensure adequate supervision when children are playing in areas near parked MVs; 2) never leave children alone in an MV, even when they are asleep or restrained; and 3) keep MVs locked in a garage or driveway and keep keys out of children's reach.

Laws related to endangering the life or health of a child by leaving the child unattended in an MV have been enacted by 11 states; the nature of these laws and associated penalties vary by state. In California, funds from 70% of fines resulting from noncompliance with its associated law will go to counties to support public education campaigns to address these preventable deaths and injuries.

Children might be protected further by commercially available vehicle enhancements, such as sensors that detect unseen obstacles behind an MV or devices that emit audible signals when an MV is in reverse. Evaluation of such interventions should be conducted to inform policy makers about their effectiveness in reducing nontraffic MV-related injuries and deaths among children.

Acknowledgments

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Public Health Dispatch

Certification of Poliomyelitis Eradication — European Region, June 2002

On June 21, 2002, the Regional Commission for the Certification of Poliomyelitis Eradication (the Commission) certified that the European Region (EUR)* of the World Health

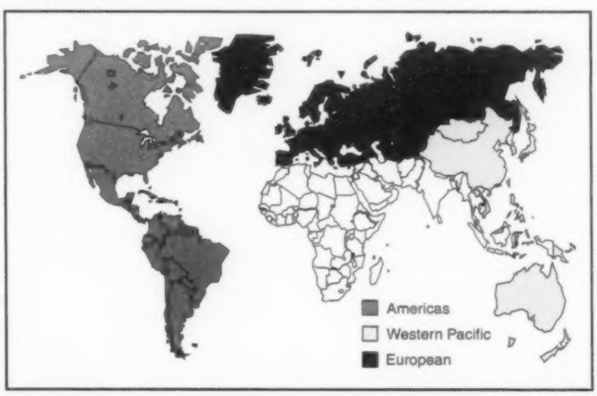
*Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, The Former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom, Uzbekistan, and the Federal Republic of Yugoslavia.

Organization (WHO) is free of indigenous wild poliovirus transmission. The last known case in EUR of polio caused by indigenous wild poliovirus transmission occurred in southeast Turkey in November 1998. EUR comprises 51 countries with an estimated population of 873 million and is the third of the six WHO regions to be certified as polio-free, following the Americas Region in 1994 (*1*) and the Western Pacific Region in 2000 (*2*) (Figure). An estimated 3.4 billion persons (55% of the world's population) live in countries and territories certified free of endemic polio.

The Commission completed a 4-year review of programmatic data compiled by national certification committees to ensure that the absence of reported wild poliovirus isolation reflected interruption of indigenous wild transmission. The prerequisite for regional certification is the absence of indigenous wild poliovirus isolation for at least 3 years (*3*). Other criteria used to certify that regions are polio-free include 1) high vaccination coverage rates in all countries and within all areas of a country, 2) sensitive surveillance for acute flaccid paralysis (AFP) meeting standard performance indicators[†] and/or other means of sensitive virologic surveillance, 3) a plan of action to respond to imported cases of wild poliovirus, and 4) political commitment by national governments to maintain high levels of vaccination coverage and surveillance through global certification of polio eradication. In addition, the Commission sought evidence of substantial progress in the process of laboratory containment of wild poliovirus in each country.

[†]The quality of AFP surveillance is evaluated by two key indicators: sensitivity of reporting (target: nonpolio AFP rate of ≥ 1 cases per 100,000 children aged <15 years) and completeness of specimen collection (target: two adequate stool specimens from $\geq 80\%$ of all persons with AFP). All stool samples should be analyzed in WHO-accredited laboratories.

FIGURE. World Health Organization regions certified free of wild poliovirus*



*Americas Region certified 1994; Western Pacific Region certified 2000; European Region certified 2002.

In 1988, the Global Polio Eradication Initiative was launched by the World Health Assembly; the initiative is coordinated by WHO in primary partnership with Rotary International, the United Nations Children's Fund (UNICEF), and CDC. National governments, private foundations, nongovernment organizations, corporations, and volunteers are collaborating to achieve eradication. During 2001, a total of 10 countries in three WHO regions (African, Eastern Mediterranean, and Southeast Asia) reported transmission of wild poliovirus (*4*).

Until polio is eradicated globally, all polio-free countries are at risk for wild poliovirus importation. In EUR, this risk was underscored by the discovery of poliovirus in Bulgaria (*5*) and Georgia in 2001[§]. During 2000–2001, two outbreaks of polio caused by circulating vaccine-derived poliovirus were documented among populations with low vaccination coverage on the island of Hispaniola (the Dominican Republic and Haiti) and the Philippines (*6*). Polio-free countries should maintain high levels of polio vaccination coverage and sensitive surveillance for the prompt detection of any circulating poliovirus. To minimize the risk for poliovirus spread, supplementary vaccination campaigns will continue in high-risk areas of some EUR countries. Many of these campaigns are synchronized with those of countries of the Eastern Mediterranean Region (EMR). During 1995–2002, Operation MECACAR (Eastern Mediterranean, Caucasus, and Central Asian Republics) coordinated polio eradication activities among 18 EUR and EMR countries; this effort represented a major advance toward eliminating virus circulation (*7,8*).

Reported by: *Vaccine-preventable Diseases and Immunization Programme, World Health Organization Regional Office for Europe, Copenhagen, Denmark. Dept of Vaccines and Biologicals, World Health Organization, Geneva, Switzerland. Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; Global Immunization Div, National Immunization Program, CDC.*

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[§]During March–May 2001, three cases of polio were reported in Bulgaria. In October 2001, wild poliovirus was isolated from a stool specimen of a child in Georgia with aseptic meningoencephalitis. In both instances, the wild poliovirus type 1 isolated had 98% homology with virus isolated in the Indian subcontinent. Both countries and their neighbors initiated supplementary immunization and enhanced surveillance in response.

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Notice to Readers

Food and Drug Administration Approval of a Fifth Acellular Pertussis Vaccine for Use Among Infants and Young Children — United States, 2002

On May 14, 2002, the Food and Drug Administration (FDA) approved for use an additional combined diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP) (DAPTACEL™ Aventis Pasteur, Ltd. [Toronto, Ontario]) for the first 4 doses of the diphtheria and tetanus toxoids and pertussis vaccination (DTP) series administered to infants and children aged 6 weeks–6 years (before seventh birthday). DAPTACEL™ is the fifth acellular pertussis vaccine to be licensed for use among infants and young children in the United States. Of these five, three (Tripedia®, Infanrix™, and DAPTACEL™) are distributed in the United States.

DAPTACEL™ is approved for administration as a 4-dose series at ages 2, 4, 6, and 17–20 months. The Advisory Committee on Immunization Practices (ACIP), the Committee on Infectious Diseases, the American Academy of Pediatrics, and the American Academy of Family Physicians recommend that children routinely receive a series of 5 doses of vaccine against diphtheria, tetanus, and pertussis before age 7 years (*1,2*). The first 4 doses should be administered at ages 2, 4, 6, and 15–18 months and the fifth dose at age 4–6 years. The customary age for the first dose is 2 months, but it may be given as early as age 6 weeks and up to the seventh birthday. The interval between the third and the fourth dose should be at least 6 months. Data are insufficient to evaluate the use of DAPTACEL™ as a fifth dose among children aged 4–6 years who have received DAPTACEL™ for the previous 4 doses. DAPTACEL™ may be used to complete the vaccination series in infants who have received 1 or more doses of whole-cell pertussis DTP.

The following evidence supports the use of DAPTACEL™ for the first 4 doses of the diphtheria, tetanus, and pertussis vaccination series:

1. The rates of local reactions, fever, and other common systemic symptoms following receipt of DAPTACEL™ inoculations were substantially lower than those following whole-cell pertussis vaccination (administered as DTP for doses 1–3 in controlled clinical studies (*3,4*).

2. Efficacy of 3 doses of DAPTACEL™ against pertussis disease was assessed in a double-blind, randomized, placebo-controlled trial in Sweden (*3*). Infants were assigned randomly to be vaccinated with either DAPTACEL™, another investigational acellular pertussis vaccine, whole-cell pertussis DTP vaccine, or DT vaccine as placebo at ages 2, 4, and 6 months. The mean length of follow-up was 2 years after the third dose of vaccine. In this trial, pertussis was defined according to the World Health Organization case definition (i.e., a paroxysmal cough illness lasting ≥21 days and confirmed by culture, serology, or epidemiologic link to a culture-positive household contact). The vaccine efficacy of DAPTACEL™ against WHO-defined pertussis was 84.9% (95% confidence interval [CI]=80.1%–88.6%) (*3,4*). The protective efficacy of DAPTACEL™ against mild pertussis (i.e., ≥1 day of cough with laboratory confirmation) was 77.9% (95% CI=72.6%–82.2%) (*4*). Although a serologic correlate of protection for pertussis has not been established, the antibody responses to the pertussis antigens in DAPTACEL™ among North American infants after 4 doses at ages 2, 4, 6, and 17–20 months was comparable to that achieved among Swedish infants in whom efficacy was demonstrated after three doses at age 2, 4, and 6 months (*4*).

Because of the reduced frequency of adverse reactions and demonstrated efficacy, ACIP recommends DTaP for all 5 doses of the routine diphtheria, tetanus, and pertussis vaccination series and for the remaining doses in the series for children who have started the vaccination series with whole-cell DTP vaccine (*1*). ACIP considers the data to be insufficient in terms of safety and efficacy to express a preference among different acellular pertussis vaccine formulations.

Whenever feasible, the same DTaP vaccine should be used throughout the entire vaccination series. Data are limited on the safety, immunogenicity, or efficacy of different DTaP vaccines when administered interchangeably in the primary or booster vaccination of a child. However, if the vaccine provider does not know or have available the type of DTaP vaccine the child to be vaccinated had received previously, any of the licensed DTaP vaccines may be used to complete the vaccination series (*1*).

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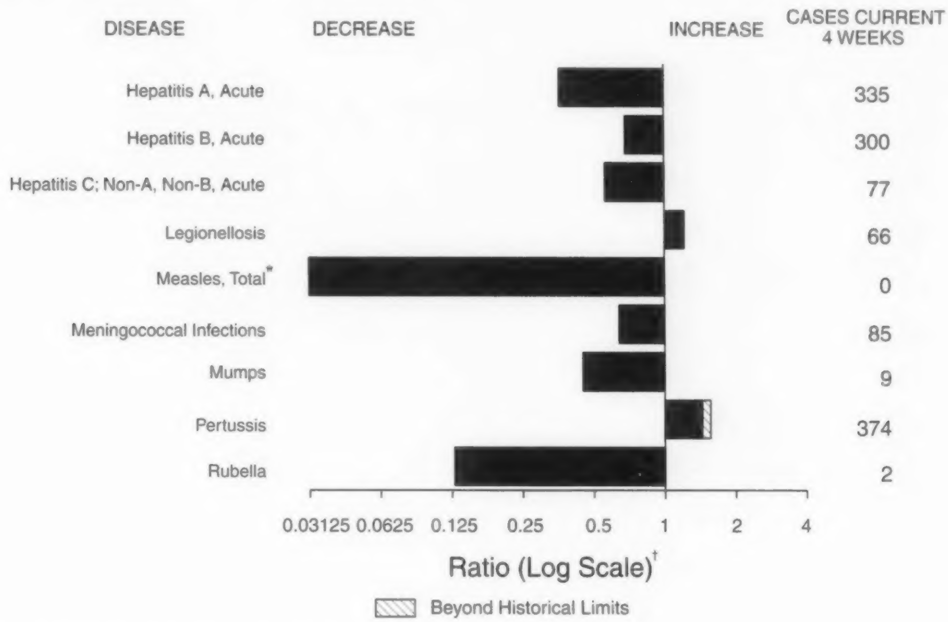
FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending June 29, 2002, with historical data



* No measles cases were reported for the current 4-week period yielding a ratio for week 26 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending June 29, 2002 (26th Week)*

		Cum. 2002	Cum. 2001		Cum. 2002	Cum. 2001
Anthrax		1	1	Encephalitis: West Nile†	1	-
Botulism:	foodborne	7	10	Hansen disease (leprosy)†	37	37
	infant	30	48	Hantavirus pulmonary syndrome†	6	5
	other (wound & unspecified)	9	6	Hemolytic uremic syndrome, postdiarrheal†	64	53
Brucellosis†		39	60	HIV infection, pediatric†§	31	91
Chancroid		29	21	Plague	-	2
Cholera		3	2	Poliomyelitis, paralytic	-	-
Cyclosporiasis†		71	53	Psittacosis†	12	7
Diphtheria		-	1	Q fever†	15	7
Ehrlichiosis:	human granulocytic (HGE)†	75	42	Rabies, human	1	-
	human monocytic (HME)†	36	36	Streptococcal toxic-shock syndrome†	38	51
	other and unspecified	2	2	Tetanus	6	22
Encephalitis:	California serogroup viral†	5	2	Toxic-shock syndrome	59	64
	eastern equine†	1	-	Trichinosis	9	8
	Powassan†	-	-	Tularemia†	21	46
	St. Louis†	-	-	Yellow fever	1	-
	western equine†	-	-			

-:No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update May 26, 2002.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending June 29, 2002, and June 30, 2001 (26th Week)*

	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7		*Escherichia coli* Shiga Toxin Positive, Serogroup non-O157	
Reporting Area	Cum. 2002§	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	16,795	20,471	352,021	377,270	946	963	806	887	33	39
NEW ENGLAND	637	731	12,724	10,897	48	44	64	91	6	18
Maine	19	20	719	624	2	3	2	11	-	-
N.H.	17	15	788	667	13	2	6	12	-	3
Vt.	6	10	317	292	8	13	2	3	-	-
Mass.	318	401	5,290	4,224	12	19	32	50	2	4
R.I.	50	51	1,368	1,389	8	3	5	4	-	-
Conn.	227	234	4,242	3,701	5	4	17	11	4	11
MID. ATLANTIC	3,498	5,435	35,378	40,354	108	135	59	65	-	-
Upstate N.Y.	259	807	7,995	6,374	32	40	47	41	-	-
N.Y. City	1,838	3,022	14,154	14,728	51	58	3	5	-	-
N.J.	668	920	2,946	6,884	7	6	9	19	-	-
Pa.	733	686	10,283	12,368	18	31	N	N	-	-
E.N. CENTRAL	1,779	1,406	55,522	69,919	230	319	199	207	1	2
Ohio	316	234	10,865	17,911	63	52	40	52	1	1
Ind.	207	163	7,848	7,842	21	30	20	31	-	-
Ill.	815	670	15,499	20,902	36	32	65	51	-	-
Mich.	358	261	15,463	15,182	49	67	33	24	-	1
Wis.	83	78	5,847	8,082	61	138	41	49	-	-
W.N. CENTRAL	270	449	17,743	19,432	109	89	111	103	4	2
Minn.	56	81	4,657	3,920	48	32	37	40	3	-
Iowa	42	47	629	2,430	11	23	23	16	-	-
Mo.	117	209	7,072	6,826	16	17	22	19	-	-
N. Dak.	-	1	469	522	6	4	3	1	-	-
S. Dak.	2	18	1,105	900	5	4	10	6	1	1
Nebr.	23	47	589	1,733	16	9	9	11	-	1
Kans.	30	46	3,222	3,101	7	-	7	10	-	-
S. ATLANTIC	5,478	6,116	69,303	72,569	156	157	88	78	14	12
Del.	96	115	1,343	1,445	1	1	4	1	-	-
Md.	822	753	7,270	7,660	7	26	3	4	-	-
D.C.	266	460	1,561	1,707	3	9	-	-	-	-
Va.	350	541	8,142	8,749	2	9	21	21	1	2
W. Va.	41	47	1,142	1,171	1	1	2	3	-	-
N.C.	418	379	11,708	11,277	21	15	16	25	-	-
S.C.	433	338	6,390	8,009	2	1	-	2	-	-
Ga.	922	751	13,541	14,890	80	62	31	14	9	6
Fla.	2,130	2,732	18,206	17,661	39	33	11	8	4	4
E.S. CENTRAL	768	954	24,770	24,812	66	18	39	46	-	-
Ky.	122	201	4,120	4,374	1	2	12	21	-	-
Tenn.	341	271	7,732	7,340	33	3	19	16	-	-
Ala.	144	224	7,674	6,945	28	6	4	6	-	-
Miss.	161	258	5,244	6,153	4	7	4	3	-	-
W.S. CENTRAL	1,834	2,025	52,169	53,460	13	27	10	104	-	-
Ark.	123	104	3,092	3,812	4	2	2	3	-	-
La.	442	459	9,353	8,855	4	7	-	2	-	-
Okla.	95	106	4,979	5,435	5	6	8	12	-	-
Tex.	1,174	1,356	34,745	35,358	-	12	-	87	-	-
MOUNTAIN	565	713	21,948	21,876	69	54	83	79	5	1
Mont.	6	12	1,002	1,101	4	5	9	5	-	-
Idaho	10	15	1,241	889	17	6	6	12	2	-
Wyo.	2	1	433	377	6	1	2	3	1	-
Colo.	108	153	5,200	5,938	19	17	30	31	1	1
N. Mex.	34	59	2,600	2,979	7	10	4	6	1	-
Ariz.	247	281	7,334	7,344	7	2	9	11	-	-
Utah	30	62	2,123	749	6	10	14	7	-	-
Nev.	128	130	2,015	2,499	3	3	9	4	-	-
PACIFIC	1,966	2,642	62,464	63,951	147	120	153	114	3	4
Wash.	235	285	7,097	6,819	24	U	16	26	-	-
Oreg.	181	110	3,353	3,622	21	12	43	21	3	4
Calif.	1,509	2,205	48,240	50,213	101	105	70	58	-	-
Alaska	9	14	1,746	1,354	-	-	4	2	-	-
Hawaii	32	28	2,028	1,943	1	3	20	7	-	-
Guam	2	8	-	202	-	-	N	N	-	-
P.R.	503	578	1,576	1,424	-	-	-	-	-	-
V.I.	57	2	30	88	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	110	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Chlamydia refers to genital infections caused by *C. trachomatis*.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update May 26, 2002.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 29, 2002, and June 30, 2001 (26th Week)*

Reporting Area	*Escherichia coli* Shiga Toxin Positive, Not Serogrouped		Giardiasis	Gonorrhea		*Haemophilus influenzae*, Invasive: All Ages, All Serotypes		*Haemophilus influenzae*, Invasive: Age <5 Years, Serotype B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	13	4	6,606	148,815	169,747	828	836	11	14
NEW ENGLAND	-	1	698	3,693	2,923	58	54	-	1
Maine	-	-	77	53	68	1	1	-	-
N.H.	-	-	24	62	72	5	-	-	-
Vt.	-	1	49	44	39	3	2	-	-
Mass.	-	-	330	1,649	1,253	27	33	-	1
R.I.	-	-	60	460	348	9	2	-	-
Conn.	-	-	158	1,425	1,143	13	16	-	-
MID. ATLANTIC	-	-	1,493	16,527	18,368	151	119	2	3
Upstate N.Y.	-	-	505	4,094	3,942	68	39	2	-
N.Y. City	-	-	605	5,726	6,118	34	32	-	-
N.J.	-	-	141	2,736	2,299	31	27	-	-
Pa.	-	-	242	3,971	6,009	18	21	-	3
E.N. CENTRAL	5	2	1,220	26,320	35,611	140	143	2	1
Ohio	5	2	380	5,909	9,602	54	46	-	1
Ind.	-	-	-	3,377	3,257	28	22	1	-
Ill.	-	-	288	8,388	11,214	43	50	-	-
Mich.	-	-	383	6,804	8,706	9	8	1	-
Wis.	-	-	169	1,842	2,832	6	17	-	-
W.N. CENTRAL	-	-	776	7,259	7,904	27	36	-	1
Minn.	-	-	276	1,374	1,215	17	18	-	-
Iowa	-	-	108	170	594	1	-	-	-
Mo.	-	-	226	4,112	4,013	7	12	-	-
N. Dak.	-	-	11	27	18	-	4	-	-
S. Dak.	-	-	30	129	139	-	-	-	-
Nebr.	-	-	52	137	594	-	1	-	1
Kans.	-	-	73	1,310	1,331	2	1	-	-
S. ATLANTIC	-	-	1,137	40,402	44,297	208	204	1	1
Del.	-	-	21	808	819	-	-	-	-
Md.	-	-	44	4,035	4,349	47	52	1	-
D.C.	-	-	20	1,295	1,459	-	-	-	-
Va.	-	-	99	5,147	4,596	15	17	-	-
W. Va.	-	-	18	479	300	6	6	-	1
N.C.	-	-	-	7,959	8,777	21	29	-	-
S.C.	-	-	30	3,758	6,017	11	4	-	-
Ga.	-	-	452	7,379	8,014	63	55	-	-
Fla.	-	-	453	9,542	9,966	45	41	-	-
E.S. CENTRAL	-	1	155	14,042	15,821	26	56	1	-
Ky.	-	1	-	1,623	1,677	2	2	-	-
Tenn.	-	-	68	4,352	4,799	15	27	-	-
Ala.	-	-	87	4,931	5,414	6	25	1	-
Miss.	-	-	-	3,136	3,931	3	2	-	-
W.S. CENTRAL	-	-	71	22,804	25,829	33	32	2	1
Ark.	-	-	59	1,718	2,383	1	-	-	-
La.	-	-	1	5,785	6,107	2	6	-	-
Okla.	-	-	11	2,158	2,464	28	25	-	-
Tex.	-	-	-	13,143	14,875	2	1	2	1
MOUNTAIN	8	-	610	4,649	5,163	114	96	2	3
Mont.	-	-	34	47	63	-	-	-	-
Idaho	-	-	38	40	41	2	1	-	-
Wyo.	-	-	10	30	31	1	-	-	-
Colo.	8	-	208	1,474	1,574	21	26	-	-
N. Mex.	-	-	71	493	469	18	14	-	-
Ariz.	-	-	80	1,785	2,029	54	40	1	1
Utah	-	-	108	171	66	13	5	-	-
Nev.	-	-	61	609	890	5	10	1	2
PACIFIC	-	-	446	13,119	13,831	71	96	1	3
Wash.	-	-	173	1,405	1,459	2	1	1	-
Oreg.	-	-	184	396	573	37	30	-	-
Calif.	-	-	-	10,729	11,299	9	43	-	3
Alaska	-	-	43	295	182	1	3	-	-
Hawaii	-	-	46	294	318	22	19	-	-
Guam	-	-	-	-	24	-	-	-	-
P.R.	-	-	1	235	326	-	1	-	-
V.I.	-	-	-	17	14	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	10	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.

* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 29, 2002, and June 30, 2001 (26th Week)*

Reporting Area	*Haemophilus influenzae*, Invasive — Age <5 Years — Non-Serotype B Cum. 2002	Non-Serotype B Cum. 2001	Unknown Serotype Cum. 2002	Unknown Serotype Cum. 2001	Hepatitis (Viral, Acute), By Type — A Cum. 2002	A Cum. 2001	B Cum. 2002	B Cum. 2001	C; Non-A, Non-B Cum. 2002	C; Non-A, Non-B Cum. 2001
UNITED STATES	130	145	11	16	4,110	4,411	3,075	3,401	1,537	2,094
NEW ENGLAND	7	10	-	-	171	235	107	67	18	26
Maine	-	-	-	-	6	5	4	5	-	-
N.H.	-	-	-	-	10	6	10	10	-	-
Vt.	-	-	-	-	-	6	2	4	11	6
Mass.	4	7	-	-	79	85	56	12	7	20
R.I.	-	-	-	-	24	9	17	12	-	-
Conn.	3	3	-	-	52	124	18	24	-	-
MID. ATLANTIC	21	20	1	2	513	580	689	671	711	587
Upstate N.Y.	8	6	-	1	98	131	74	64	29	18
N.Y. City	6	5	-	-	213	214	378	326	-	-
N.J.	4	3	-	-	61	136	142	130	668	536
Pa.	3	6	1	1	141	99	95	151	14	33
E.N. CENTRAL	19	28	-	1	532	530	392	399	55	105
Ohio	5	8	-	-	162	126	47	58	5	7
Ind.	6	4	-	1	28	40	17	22	-	1
Ill.	7	11	-	-	158	160	34	49	7	8
Mich.	-	-	-	-	124	164	294	249	43	89
Wis.	1	5	-	-	60	40	-	21	-	-
W.N. CENTRAL	2	2	3	2	177	187	109	109	457	661
Minn.	2	1	1	-	25	14	8	11	-	2
Iowa	-	-	-	-	41	18	10	11	1	-
Mo.	-	-	2	2	49	40	62	63	448	653
N. Dak.	-	1	-	-	1	2	4	-	-	-
S. Dak.	-	-	-	-	3	1	-	1	-	-
Nebr.	-	-	-	-	5	25	14	13	6	3
Kans.	-	-	-	-	53	87	11	10	2	3
S. ATLANTIC	30	27	1	5	1,250	810	796	617	78	33
Del.	-	-	-	-	9	4	7	11	3	2
Md.	1	4	-	1	154	114	66	69	6	3
D.C.	-	-	-	-	46	21	10	8	-	-
Va.	2	4	-	-	47	67	105	76	2	-
W. Va.	-	-	1	-	10	6	13	14	1	6
N.C.	3	1	-	4	128	64	132	109	14	9
S.C.	4	1	-	-	42	30	40	13	4	4
Ga.	13	13	-	-	306	449	254	185	21	-
Fla.	7	4	-	-	508	55	169	132	27	9
E.S. CENTRAL	7	11	-	2	142	178	166	224	94	130
Ky.	-	-	-	1	34	38	23	25	2	5
Tenn.	5	5	-	-	58	72	71	110	18	36
Ala.	2	5	-	1	23	56	37	46	3	2
Miss.	-	1	-	-	27	12	35	43	71	87
W.S. CENTRAL	6	4	-	-	64	508	181	416	14	440
Ark.	-	-	-	-	24	31	58	54	3	5
La.	1	-	-	-	15	56	14	64	11	101
Okla.	5	4	-	-	24	80	1	58	-	4
Tex.	-	-	-	-	1	341	108	240	-	330
MOUNTAIN	24	12	5	1	320	384	239	251	45	34
Mont.	-	-	-	-	9	6	3	2	-	1
Idaho	1	-	-	-	20	35	4	7	-	1
Wyo.	-	-	-	-	2	2	9	-	6	4
Colo.	2	-	-	-	53	36	48	56	21	5
N. Mex.	4	6	1	1	8	15	41	65	-	10
Ariz.	12	4	3	-	169	206	88	82	3	9
Utah	4	2	-	-	33	38	19	15	2	1
Nev.	1	-	1	-	26	46	27	24	13	3
PACIFIC	14	31	1	3	941	999	396	647	65	78
Wash.	1	-	-	1	86	52	30	59	12	16
Oreg.	4	5	-	-	46	63	74	80	12	10
Calif.	6	24	1	1	801	863	286	491	41	52
Alaska	1	1	-	-	7	12	3	4	-	-
Hawaii	2	1	-	1	1	9	3	13	-	-
Guam	-	-	-	-	-	1	-	-	-	-
P.R.	-	1	-	-	47	93	31	133	-	1
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	29	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 29, 2002, and June 30, 2001 (26th Week)*

Reporting Area	Legionellosis		Listeriosis		Lyme Disease		Malaria		Measles Total	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	346	422	186	243	2,762	3,781	521	613	9†	79§
NEW ENGLAND	15	18	21	23	177	869	32	39	-	5
Maine	2	1	2	-	-	-	1	3	-	-
N.H.	2	4	2	-	38	20	5	2	-	-
Vt.	1	4	-	-	3	4	1	-	-	1
Mass.	6	4	14	13	103	390	11	17	-	3
R.I.	-	1	1	1	33	70	3	3	-	-
Conn.	4	4	2	9	-	385	11	14	-	1
MID. ATLANTIC	82	90	34	43	2,063	2,086	114	155	5	10
Upstate N.Y.	26	28	15	13	1,364	558	20	20	-	4
N.Y. City	17	7	9	11	75	36	71	93	5	2
N.J.	10	5	3	6	149	700	13	24	-	1
Pa.	29	50	7	13	475	792	10	18	-	3
E.N. CENTRAL	81	120	23	35	27	316	59	82	-	10
Ohio	38	52	9	6	23	8	11	10	-	3
Ind.	8	8	3	4	4	4	2	12	-	4
Ill.	-	15	1	10	-	18	16	33	-	3
Mich.	27	25	8	13	-	2	23	17	-	-
Wis.	8	20	2	2	U	284	7	10	-	-
W.N. CENTRAL	21	28	8	6	57	73	40	17	-	4
Minn.	2	6	-	-	31	39	14	6	-	2
Iowa	4	6	1	-	7	11	2	1	-	-
Mo.	10	9	5	3	15	20	9	6	-	2
N. Dak.	-	1	1	-	-	-	1	-	-	-
S. Dak.	1	2	-	-	-	-	-	-	-	-
Nebr.	4	3	-	1	-	1	5	2	-	-
Kans.	-	1	1	2	4	2	9	2	-	-
S. ATLANTIC	83	56	30	28	347	320	146	127	1	4
Del.	5	-	-	1	44	39	1	1	-	-
Md.	13	16	4	3	192	207	39	53	-	3
D.C.	3	2	-	-	10	7	7	9	-	-
Va.	8	7	3	5	22	56	11	26	-	-
W. Va.	N	N	-	4	3	1	2	1	-	-
N.C.	5	5	3	-	46	7	9	2	-	-
S.C.	5	1	3	2	3	2	4	4	-	-
Ga.	10	8	10	7	1	-	51	20	-	1
Fla.	34	17	7	6	26	1	22	11	1	-
E.S. CENTRAL	10	35	8	9	18	17	8	13	-	2
Ky.	5	8	2	3	8	5	2	3	-	2
Tenn.	1	15	3	3	4	7	2	6	-	-
Ala.	4	8	3	3	6	3	3	3	-	-
Miss.	-	4	-	-	-	2	1	1	-	-
W.S. CENTRAL	3	15	3	22	2	53	3	42	-	1
Ark.	-	-	-	1	-	-	1	3	-	-
La.	1	6	-	-	1	3	2	3	-	-
Okla.	2	3	3	1	-	-	-	2	-	-
Tex.	-	6	-	20	1	50	-	34	-	1
MOUNTAIN	20	26	17	23	12	5	24	27	-	1
Mont.	1	-	-	-	-	-	-	2	-	-
Idaho	-	1	2	1	2	2	-	3	-	1
Wyo.	4	2	-	1	-	1	-	-	-	-
Colo.	4	10	2	5	3	-	13	14	-	-
N. Mex.	1	1	2	5	1	-	1	1	-	-
Ariz.	3	8	8	5	2	-	4	3	-	-
Utah	6	2	3	1	3	-	3	2	-	-
Nev.	1	2	-	5	1	2	3	2	-	-
PACIFIC	31	34	42	54	59	42	95	111	3	42
Wash.	3	6	3	3	-	1	9	4	-	15
Oreg.	N	N	2	4	7	4	4	8	-	2
Calif.	28	23	32	46	51	35	74	91	3	19
Alaska	-	1	-	-	1	2	2	1	-	-
Hawaii	-	4	5	1	N	N	6	7	-	6
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	2	1	-	N	N	-	3	-	-
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Of nine cases reported, three were indigenous and six were imported from another country.
§ Of 79 cases reported, 36 were indigenous and 43 were imported from another country.

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 29, 2002, and June 30, 2001 (26th Week)*

Reporting Area	Meningococcal Disease		Mumps		Pertussis		Rabies, Animal	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	894	1,447	148	116	2,884	2,506	2,575	3,450
NEW ENGLAND	60	71	7	-	303	236	387	309
Maine	4	1	-	-	3	-	22	36
N.H.	7	9	4	-	6	10	11	6
Vt.	4	4	-	-	49	23	58	37
Mass.	30	42	2	-	238	187	132	106
R.I.	4	2	-	-	1	2	29	29
Conn.	11	13	1	-	6	14	135	95
MID. ATLANTIC	84	152	14	12	142	170	449	547
Upstate N.Y.	31	44	2	2	101	96	273	337
N.Y. City	11	25	1	7	7	30	10	14
N.J.	11	25	1	-	3	8	67	92
Pa.	31	58	10	3	31	36	99	104
E.N. CENTRAL	141	205	17	17	342	288	34	36
Ohio	53	57	3	1	203	155	10	14
Ind.	23	22	1	1	22	20	7	1
Ill.	27	49	6	12	55	34	7	4
Mich.	26	47	7	2	32	27	10	11
Wis.	12	30	-	1	30	52	-	6
W.N. CENTRAL	80	97	11	5	280	116	203	182
Minn.	20	14	3	2	92	31	16	18
Iowa	11	20	-	-	97	15	28	40
Mo.	32	35	3	-	56	51	19	14
N. Dak.	-	5	1	-	-	-	11	24
S. Dak.	2	4	-	-	5	3	32	25
Nebr.	10	10	-	1	4	2	-	1
Kans.	5	9	4	2	26	14	97	60
S. ATLANTIC	152	213	17	17	194	117	1,123	1,203
Del.	6	1	-	-	2	-	24	22
Md.	4	31	3	4	21	18	138	251
D.C.	-	-	-	-	1	1	-	-
Va.	27	25	3	2	88	12	256	218
W. Va.	-	6	-	-	6	1	85	65
N.C.	17	50	1	1	20	40	329	299
S.C.	14	22	2	1	26	21	41	66
Ga.	21	33	4	7	14	14	132	183
Fla.	63	45	4	2	16	10	118	99
E.S. CENTRAL	52	92	10	3	76	47	80	140
Ky.	8	15	4	1	22	13	13	11
Tenn.	21	38	2	-	36	18	48	106
Ala.	15	29	2	-	18	13	19	23
Miss.	8	10	2	2	-	3	-	-
W.S. CENTRAL	54	226	11	9	656	228	57	709
Ark.	20	12	-	-	315	11	-	-
La.	17	55	1	2	4	4	-	4
Okla.	16	18	-	-	34	9	57	42
Tex.	1	141	10	7	303	204	-	663
MOUNTAIN	61	70	9	8	424	881	115	130
Mont.	2	2	-	-	2	9	5	18
Idaho	3	7	1	-	46	163	2	2
Wyo.	-	4	-	1	7	-	13	20
Colo.	20	27	2	2	170	163	16	-
N. Mex.	3	8	-	2	68	48	4	4
Ariz.	18	11	-	1	89	461	72	84
Utah	4	7	4	1	26	26	2	1
Nev.	11	4	2	1	16	11	1	1
PACIFIC	210	321	52	45	467	423	127	194
Wash.	38	42	-	1	174	66	-	-
Oreg.	33	37	N	N	88	26	2	-
Calif.	132	232	43	25	196	312	101	157
Alaska	1	2	-	1	2	1	24	37
Hawaii	6	8	9	18	7	18	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	2	4	-	-	1	-	41	60
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.

* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 29, 2002, and June 30, 2001 (26th Week)*

	Rocky Mountain Spotted Fever		Rubella: Rubella		Rubella: Congenital Rubella		Salmonellosis	
Reporting Area	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	272	155	6	14	2	-	13,358	14,894
NEW ENGLAND	-	2	-	-	-	-	811	1,091
Maine	-	-	-	-	-	-	67	101
N.H.	-	-	-	-	-	-	46	87
Vt.	-	-	-	-	-	-	29	35
Mass.	-	2	-	-	-	-	451	623
R.I.	-	-	-	-	-	-	53	54
Conn.	-	-	-	-	-	-	165	191
MID. ATLANTIC	14	11	2	5	-	-	1,697	2,018
Upstate N.Y.	3	-	1	1	-	-	597	454
N.Y. City	2	1	-	3	-	-	565	546
N.J.	2	2	1	1	-	-	188	468
Pa.	7	8	-	-	-	-	347	550
E.N. CENTRAL	4	10	-	2	-	-	2,213	2,061
Ohio	4	1	-	-	-	-	624	615
Ind.	-	1	-	-	-	-	185	192
Ill.	-	8	-	2	-	-	689	573
Mich.	-	-	-	-	-	-	397	359
Wis.	-	-	-	-	-	-	318	322
W.N. CENTRAL	37	28	-	3	-	-	1,030	883
Minn.	-	-	-	-	-	-	228	274
Iowa	1	1	-	1	-	-	162	137
Mo.	36	25	-	1	-	-	401	214
N. Dak.	-	-	-	-	-	-	25	15
S. Dak.	-	2	-	-	-	-	38	55
Nebr.	-	-	-	-	-	-	51	64
Kans.	-	-	-	1	-	-	125	124
S. ATLANTIC	170	56	2	3	-	-	3,238	3,144
Del.	2	-	-	-	-	-	20	33
Md.	21	11	1	-	-	-	332	331
D.C.	-	-	-	-	-	-	36	33
Va.	7	4	-	-	-	-	364	498
W. Va.	1	-	-	-	-	-	43	49
N.C.	92	23	-	-	-	-	495	461
S.C.	28	10	-	2	-	-	193	323
Ga.	16	5	-	-	-	-	749	571
Fla.	3	3	1	1	-	-	1,006	845
E.S. CENTRAL	28	34	-	-	1	-	833	836
Ky.	2	1	-	-	-	-	129	148
Tenn.	18	27	-	-	1	-	214	223
Ala.	8	3	-	-	-	-	267	242
Miss.	-	3	-	-	-	-	223	223
W.S. CENTRAL	13	9	1	-	-	-	516	1,749
Ark.	-	4	-	-	-	-	259	219
La.	-	1	-	-	-	-	97	310
Okla.	13	4	-	-	-	-	158	121
Tex.	-	-	1	-	-	-	2	1,099
MOUNTAIN	5	5	-	-	-	-	943	925
Mont.	1	1	-	-	-	-	42	37
Idaho	-	1	-	-	-	-	57	57
Wyo.	2	1	-	-	-	-	27	30
Colo.	1	-	-	-	-	-	244	253
N. Mex.	-	-	-	-	-	-	130	114
Ariz.	-	-	-	-	-	-	277	254
Utah	-	2	-	-	-	-	73	102
Nev.	1	-	-	-	-	-	93	78
PACIFIC	1	-	1	1	1	-	2,077	2,187
Wash.	-	-	-	-	-	-	179	208
Oreg.	-	-	-	-	-	-	190	128
Calif.	1	-	1	-	-	-	1,549	1,667
Alaska	-	-	-	-	-	-	36	23
Hawaii	-	-	-	1	1	-	123	161
Guam	-	-	-	-	-	-	-	9
P.R.	-	-	-	3	-	-	69	454
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	18	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 29, 2002, and June 30, 2001 (26th Week)*

Reporting Area	Shigellosis		Streptococcal Disease, Invasive, Group A		*Streptococcus pneumoniae*, Drug Resistant, Invasive		*Streptococcus pneumoniae*, Invasive (<5 Years)	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	6,284	7,224	2,293	2,192	1,251	1,742	124	312
NEW ENGLAND	116	119	111	156	8	81	15	70
Maine	3	4	14	10	-	-	-	-
N.H.	4	2	23	9	-	-	-	-
Vt.	-	3	9	9	3	7	1	-
Mass.	83	80	55	49	N	N	14	41
R.I.	5	8	10	6	5	-	-	2
Conn.	21	22	-	73	-	74	-	27
MID. ATLANTIC	370	785	405	375	75	110	41	71
Upstate N.Y.	81	298	204	162	67	108	41	71
N.Y. City	183	213	101	117	U	U	-	-
N.J.	48	139	71	63	-	-	-	-
Pa.	58	135	29	33	8	2	-	-
E.N. CENTRAL	645	1,105	336	531	107	117	35	79
Ohio	326	480	139	135	-	-	1	-
Ind.	37	119	21	42	102	117	24	36
Ill.	172	246	4	173	2	-	-	28
Mich.	69	147	172	135	3	-	10	15
Wis.	41	113	-	46	-	-	-	-
W.N. CENTRAL	555	709	161	216	144	83	25	31
Minn.	116	236	82	80	48	40	25	24
Iowa	51	170	-	-	-	-	-	-
Mo.	69	126	35	55	6	9	-	-
N. Dak.	15	13	-	7	1	2	-	7
S. Dak.	147	83	9	7	1	3	-	-
Nebr.	104	38	13	23	23	9	-	-
Kans.	53	43	22	44	65	20	-	-
S. ATLANTIC	2,492	1,007	457	393	767	919	6	4
Del.	8	4	1	2	3	2	-	-
Md.	430	53	73	30	-	-	-	-
D.C.	29	24	5	3	33	3	1	3
Va.	453	94	50	56	-	-	-	-
W. Va.	3	5	10	14	34	34	-	1
N.C.	145	190	89	90	-	-	-	-
S.C.	43	127	27	7	121	194	5	-
Ga.	834	131	122	127	249	270	-	-
Fla.	547	379	80	64	327	416	-	-
E.S. CENTRAL	592	721	63	47	86	170	-	-
Ky.	62	268	9	18	10	18	-	-
Tenn.	27	48	54	29	76	151	-	-
Ala.	294	126	-	-	-	1	-	-
Miss.	209	279	-	-	-	-	-	-
W.S. CENTRAL	371	1,379	36	209	39	232	2	57
Ark.	97	348	4	-	5	13	-	-
La.	60	139	-	-	25	189	1	57
Okla.	213	19	31	27	9	30	1	-
Tex.	1	873	1	182	-	-	-	-
MOUNTAIN	277	383	398	239	25	29	-	-
Mont.	2	-	-	-	-	-	-	-
Idaho	2	17	5	4	-	-	-	-
Wyo.	3	2	7	7	8	5	-	-
Colo.	55	74	144	95	-	-	-	-
N. Mex.	55	56	64	49	17	22	-	-
Ariz.	126	179	173	81	-	-	-	-
Utah	19	25	5	3	-	-	-	-
Nev.	15	30	-	-	-	2	-	-
PACIFIC	866	1,016	326	26	-	1	-	-
Wash.	52	83	36	-	-	-	-	-
Oreg.	45	53	-	-	-	-	-	-
Calif.	743	851	254	-	-	-	-	-
Alaska	2	4	-	-	-	-	-	-
Hawaii	24	25	36	26	-	1	-	-
Guam	-	29	-	1	-	-	-	-
P.R.	1	10	-	-	-	-	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	-	-	U	U
C.N.M.I.	10	U	-	U	-	-	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.

* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending June 29, 2002, and June 30, 2001 (26th Week)*

Reporting Area	Syphilis: Primary & Secondary Cum. 2002	Syphilis: Primary & Secondary Cum. 2001	Syphilis: Congenital Cum. 2002	Syphilis: Congenital Cum. 2001	Tuberculosis Cum. 2002	Tuberculosis Cum. 2001	Typhoid Fever Cum. 2002	Typhoid Fever Cum. 2001
UNITED STATES	2,931	2,819	145	266	5,265	6,415	117	151
NEW ENGLAND	59	24	-	3	192	229	10	7
Maine	-	-	-	-	5	9	-	1
N.H.	1	1	-	-	7	11	-	1
Vt.	1	2	-	-	-	4	-	-
Mass.	44	13	-	2	101	110	8	4
R.I.	2	3	-	-	26	37	-	-
Conn.	11	5	-	1	53	58	2	1
MID. ATLANTIC	322	239	23	38	1,013	1,087	32	48
Upstate N.Y.	20	9	3	2	149	153	4	11
N.Y. City	194	135	10	19	530	558	18	18
N.J.	58	45	10	17	239	248	9	18
Pa.	50	50	-	-	95	128	1	1
E.N. CENTRAL	518	502	24	40	526	648	13	19
Ohio	69	47	-	2	86	123	4	2
Ind.	35	90	-	5	53	44	2	2
Ill.	129	149	18	26	270	329	1	9
Mich.	277	199	6	4	111	116	3	3
Wis.	8	17	-	3	6	36	3	3
W.N. CENTRAL	48	41	-	5	242	249	4	6
Minn.	18	19	-	1	108	106	3	2
Iowa	-	2	-	-	14	18	-	-
Mo.	16	9	-	3	71	59	1	4
N. Dak.	-	-	-	-	1	3	-	-
S. Dak.	-	-	-	-	9	6	-	-
Nebr.	4	1	-	-	9	19	-	-
Kans.	10	10	-	1	30	38	-	-
S. ATLANTIC	748	999	30	68	1,023	1,265	13	19
Del.	8	8	-	-	7	9	-	-
Md.	90	131	3	2	120	103	2	5
D.C.	44	14	1	2	-	37	-	-
Va.	37	60	1	3	77	118	-	5
W. Va.	-	-	-	-	10	15	-	-
N.C.	152	233	13	8	155	173	-	1
S.C.	62	141	3	18	80	113	-	-
Ga.	112	157	1	13	167	223	7	6
Fla.	243	255	8	22	407	474	4	2
E.S. CENTRAL	266	296	10	21	355	409	4	-
Ky.	44	23	2	-	62	61	4	-
Tenn.	106	165	3	13	133	149	-	-
Ala.	88	50	4	4	114	135	-	-
Miss.	28	58	1	4	46	64	-	-
W.S. CENTRAL	408	342	39	44	701	1,036	-	10
Ark.	12	21	1	5	66	67	-	-
La.	65	67	-	-	-	65	-	-
Okla.	30	34	2	3	62	68	-	-
Tex.	301	220	36	36	573	836	-	10
MOUNTAIN	147	109	9	14	161	236	8	6
Mont.	-	-	-	-	4	-	-	1
Idaho	7	-	1	-	8	3	-	-
Wyo.	-	-	-	-	2	1	-	-
Colo.	10	15	1	-	22	63	4	-
N. Mex.	21	9	-	1	17	33	-	-
Ariz.	100	76	7	13	92	85	-	1
Utah	6	6	-	-	14	11	3	-
Nev.	3	3	-	-	2	40	1	4
PACIFIC	415	267	10	33	1,052	1,256	33	36
Wash.	24	31	1	-	111	110	3	3
Oreg.	5	7	-	-	45	50	2	3
Calif.	381	223	9	33	799	995	28	28
Alaska	-	-	-	-	28	23	-	-
Hawaii	5	6	-	-	69	78	-	2
Guam	-	2	-	-	-	36	-	1
P.R.	120	134	10	2	33	47	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	13	U	-	U	27	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending June 29, 2002 (26th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	515	359	103	32	13	8	44
Boston, Mass.	133	76	37	8	8	4	14
Bridgeport, Conn.	29	25	3	1	-	-	1
Cambridge, Mass.	17	10	4	3	-	-	2
Fall River, Mass.	18	16	2	-	-	-	1
Hartford, Conn.	39	24	8	4	2	1	3
Lowell, Mass.	20	15	3	2	-	-	2
Lynn, Mass.	11	8	2	1	-	-	1
New Bedford, Mass.	23	15	5	2	1	-	2
New Haven, Conn.	36	25	9	1	-	1	5
Providence, R.I.	68	50	15	3	-	-	2
Somerville, Mass.	5	5	-	-	-	-	-
Springfield, Mass.	41	33	2	3	1	2	5
Waterbury, Conn.	37	25	10	2	-	-	3
Worcester, Mass.	38	32	3	2	1	-	3
MID. ATLANTIC	2,117	1,437	411	156	43	69	88
Albany, N.Y.	36	28	7	1	-	-	-
Allentown, Pa.	21	18	1	2	-	-	-
Buffalo, N.Y.	108	78	15	7	3	5	11
Camden, N.J.	23	13	4	2	-	4	3
Elizabeth, N.J.	20	14	5	1	-	-	2
Erie, Pa.	37	29	7	1	-	-	2
Jersey City, N.J.	37	27	4	4	-	2	-
New York City, N.Y.	1,052	717	214	79	25	16	27
Newark, N.J.	52	26	14	9	1	2	3
Paterson, N.J.	14	5	4	3	-	2	3
Philadelphia, Pa.	355	217	78	25	5	30	15
Pittsburgh, Pa.§	24	19	1	1	2	1	3
Reading, Pa.	18	15	1	1	-	1	2
Rochester, N.Y.	122	93	19	5	2	3	4
Schenectady, N.Y.	30	22	6	2	-	-	3
Scranton, Pa.	27	22	3	2	-	-	1
Syracuse, N.Y.	67	40	15	4	5	3	6
Trenton, N.J.	34	25	8	1	-	-	1
Utica, N.Y.	19	14	2	3	-	-	-
Yonkers, N.Y.	21	15	3	3	-	-	2
E.N. CENTRAL	1,453	970	288	118	39	38	78
Akron, Ohio	U	U	U	U	U	U	U
Canton, Ohio	32	23	9	-	-	-	2
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	U	U	U	U	U	U	U
Cleveland, Ohio	150	97	29	17	4	3	5
Columbus, Ohio	181	117	45	13	3	3	8
Dayton, Ohio	122	91	19	10	1	1	9
Detroit, Mich.	176	94	50	20	6	6	11
Evansville, Ind.	52	42	6	3	1	-	6
Fort Wayne, Ind.	46	35	5	3	1	2	4
Gary, Ind.	13	4	5	4	-	-	1
Grand Rapids, Mich.	73	47	12	7	2	5	5
Indianapolis, Ind.	217	140	41	20	9	7	8
Lansing, Mich.	U	U	U	U	U	U	U
Milwaukee, Wis.	111	84	17	7	2	1	6
Peoria, Ill.	44	25	8	4	2	5	2
Rockford, Ill.	57	39	14	2	-	2	1
South Bend, Ind.	45	34	5	3	3	-	2
Toledo, Ohio	80	57	16	3	2	2	6
Youngstown, Ohio	54	41	7	2	3	1	2
W.N. CENTRAL	481	287	116	28	30	20	25
Des Moines, Iowa	U	U	U	U	U	U	U
Duluth, Minn.	23	16	6	-	-	1	-
Kansas City, Kans.	37	18	9	4	5	1	4
Kansas City, Mo.	94	52	25	1	8	8	3
Lincoln, Nebr.	31	23	5	2	1	-	1
Minneapolis, Minn.	81	43	19	9	4	6	5
Omaha, Nebr.	80	48	21	6	4	1	6
St. Louis, Mo.	U	U	U	U	U	U	U
St. Paul, Minn.	48	34	12	1	-	1	3
Wichita, Kans.	87	53	19	5	8	2	3
S. ATLANTIC	1,041	663	228	85	43	21	56
Atlanta, Ga.	165	103	44	12	4	2	5
Baltimore, Md.	167	99	32	22	12	2	14
Charlotte, N.C.	95	65	19	4	3	3	9
Jacksonville, Fla.	U	U	U	U	U	U	U
Miami, Fla.	112	77	17	12	4	2	3
Norfolk, Va.	50	37	6	2	1	4	1
Richmond, Va.	63	34	16	8	4	1	3
Savannah, Ga.	41	25	10	1	3	2	3
St. Petersburg, Fla.	57	40	12	4	1	-	2
Tampa, Fla.	177	112	48	9	4	4	14
Washington, D.C.	101	60	22	11	7	1	2
Wilmington, Del.	13	11	2	-	-	-	-
E.S. CENTRAL	668	440	144	49	24	10	46
Birmingham, Ala.	199	138	43	9	7	1	12
Chattanooga, Tenn.	61	39	16	5	1	-	4
Knoxville, Tenn.	95	69	20	3	3	-	4
Lexington, Ky.	60	41	10	7	2	-	2
Memphis, Tenn.	U	U	U	U	U	U	U
Mobile, Ala.	47	30	9	4	4	-	4
Montgomery, Ala.	52	35	10	2	2	3	5
Nashville, Tenn.	154	88	36	19	5	6	15
W.S. CENTRAL	1,327	831	292	108	40	55	80
Austin, Tex.	95	55	22	8	8	2	1
Baton Rouge, La.	79	59	15	2	2	1	-
Corpus Christi, Tex.	39	25	7	4	1	1	3
Dallas, Tex.	U	U	U	U	U	U	U
El Paso, Tex.	61	41	13	6	1	-	3
Ft. Worth, Tex.	124	83	27	4	1	9	14
Houston, Tex.	400	224	91	42	16	27	35
Little Rock, Ark.	82	44	19	12	3	4	4
New Orleans, La.	53	25	15	8	5	-	-
San Antonio, Tex.	206	151	37	11	2	5	10
Shreveport, La.	44	29	11	2	-	2	1
Tulsa, Okla.	144	95	35	9	1	4	9
MOUNTAIN	877	581	188	72	20	16	53
Albuquerque, N.M.	107	51	37	13	3	3	2
Boise, Idaho	60	40	11	4	2	3	4
Colo. Springs, Colo.	49	30	15	2	1	1	1
Denver, Colo.	102	68	19	10	2	3	7
Las Vegas, Nev.	228	161	43	19	4	1	10
Ogden, Utah	38	27	7	3	-	1	3
Phoenix, Ariz.	U	U	U	U	U	U	U
Pueblo, Colo.	22	16	5	1	-	-	3
Salt Lake City, Utah	134	94	22	10	5	3	13
Tucson, Ariz.	137	94	29	10	3	1	10
PACIFIC	2,044	1,458	370	139	46	31	110
Berkeley, Calif.	19	12	5	1	-	1	4
Fresno, Calif.	94	66	23	3	2	-	9
Glendale, Calif.	38	34	3	-	1	-	-
Honolulu, Hawaii	90	66	17	4	1	2	4
Long Beach, Calif.	58	42	13	1	1	1	8
Los Angeles, Calif.	695	492	119	55	18	11	-
Pasadena, Calif.	24	16	3	4	-	1	1
Portland, Oreg.	189	130	37	17	5	-	13
Sacramento, Calif.	209	154	36	13	4	2	22
San Diego, Calif.	152	109	29	8	4	2	17
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	171	123	29	12	1	6	10
Santa Cruz, Calif.	36	33	2	-	1	-	4
Seattle, Wash.	111	68	22	14	5	2	10
Spokane, Wash.	54	37	13	3	1	-	4
Tacoma, Wash.	104	76	19	4	2	3	4
TOTAL	10,523¶	7,026	2,140	787	298	268	580

U: Unavailable. -:No reported cases.

* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Total includes unknown ages.

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